State of Montana
DEPARTMENT OF CORRECTIONS
MORTALITY CASE REVIEW

(To the Medical Director for Supervisory and Peer Review Purposes)

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)

AO# _____DATE OF DEATH: _____/_____/_____
AGE AT DEATH: _____

Death Occurred:

Within ODOC _____	Outside ODOC _____
_____ Infirmary	_____ Hospital
_____ Population	_____ Within 24 hours
_____ Special Housing	_____ After 24 hours
_____ Work place	_____ In Transit
_____ Other (specify)	_____ Other (specify)

History/past medical history/recent history/pertinent physical findings/medications at time of death/procedures/surgeries/consultations/diagnosis before death:

Events leading to the Terminal Event:

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)
AO# _____

Diagnosis as established at the time of this review:

Category of Death:

_____ Natural
_____ Chronic Illness, normal progression
_____ Acute Illness, less than 24 hours ill
_____ Suicide, without recent warning signs
_____ Accidental
_____ Chronic Illness, acute exacerbation
_____ Acute Illness, more than 24 hours Ill
_____ Suicide, with recent warning signs
_____ Other (Specify) _____

Reviewer's opinion of Community Standards Rating:
(1 to 5 scale, with 1 = excellent, 2 = exceeded, 3 = met, 4 = may not meet, 5 = not met)

PRODROME PERIOD	TERMINAL EVENT PERIOD
_____ Diagnosis timely	_____ Diagnosis timely
_____ Diagnosis accurate	_____ Diagnosis accurate
_____ Treatment timely	_____ Treatment timely
_____ Treatment appropriate	_____ Treatment appropriate
_____ Preventive measures taken	_____ Preventive measures taken
_____ Staff response appropriate	_____ Staff response appropriate
_____ Level of housing/care appropriate	_____ Level of housing/care appropriate

INMATE NAME _____ _____ _____
(LAST) (FIRST) (MI)

AO# _____

Conclusions – Narrative:

Reviewer's Recommendations:

_____	_____
Reviewer's Signature	Date
_____	_____
Facility Health Services Administrator's Signature	Date
_____	_____
Health Services Bureau Chief's Signature	Date